MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Integra Specialty Group, P.A. 517 N. Carrier Pkwy., Suite G Grand Prairie TX 75050	MDR Tracking No.: M5-05-1709-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Zurich American Ins. Co. c/o Flahive Ogden & Latson PO Box 13367 Austin TX 78711	Date of Injury: Employer's Name: Zurich American Ins. Co. Insurance Carrier's No.: 272004639

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
3/1/04	**8/9/04**	**99213, 97010, 97012, 97032, 97110, 97140, 97545-WC, 97546-WC 99080-73**	**$5,069.33**	**$1,537.71**

PART III: REQUESTOR'S POSITION SUMMARY

2/11/04: Requestor seeking MDR for resolution to treatment / services rendered without reimbursement and/or lack of EOB's from the Respondent on some dates of service (DOS) mentioned above.

PART IV: RESPONDENT'S POSITION SUMMARY

3/11/04 & 4/5/04: "The provide has requested reimbursement…Some of those services included work conditioning between 6/7/04 and 7/9/04. The carrier preauthorized…between 5/24/04 and 6/20/04 for a total of 15 visits…However the provider exceeded that period…those services not covered by the preauthorization…should be dismissed…In addition…provider calculated at the rate for work hardening rather than work conditioning. The provider is not CARF accredited…should have been billing at a rate of $28.80…Commission Rule 134.202(e)(5)(B) and (C)."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- The TWCC-60 request was received by MDR on 2/15/04, and was sent to IRO due to medical necessity issues.

- On 3/4/05, the Requestor withdrew medical necessity issues on DOS 3/1/04, 4/5/04, 4/19/04, and 8/9/04 therefore these DOS will not be mentioned further in this Finding and Decision.

- In addition to the dates withdrawn, per the EOB dated 8/6/04, DOS 6/21/04 and 6/22/04 were also denied for medical necessity. The next DOS, 6/23/04 and 6/24/04, were reimbursed by the Respondent. The preauthorization for the work conditioning was certified (#040603-011922) from 5/24/04 – 6/30/04 (15 visits). Therefore DOS 6/21/04 and 6/22/04 were incorrectly denied and reimbursement is recommended. As well, DOS 7/7/04, 7/8/04 and 7/9/04, the last three (3) dates of the 15 days preauthorized for the work conditioning, were denied incorrectly for medical necessity. Per telephone conversation documented on 7/22/04, between the provider, Dr. Sloan and the UR review person, Ms. Carney, an extension was granted for the timeframe of the preauthorized treatment to end on 7/9/04. Therefore, as medical necessity was established with the preauthorization that was given on 5/20/04,

reimbursement recommended:

Amount due as follows:

CPT code **97545** and **97546-**work conditioning: Rule 134.202 (e) (5) (A) (ii). If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR amount.

a) The EOB's indicated the Requestor was properly reimbursed at 80% ($36.00 per hour x 80%=$28.80) for DOS 6/7/04 – 6/18/04 and 6/23/04 – 6/24/04.

b) Reimbursement recommended for the remaining five (5) DOS:

6/21/04:	97545-WC - 1 unit (=$28.80 x 2)	= $57.60
	97546-WC - 6 hrs (x $28.80)	= $172.80
6/22/04:	97545-WC - 1 unit (=$28.80 x 2)	= $57.60
	97546-WC - 6 hrs (x $28.80)	= $172.80
7/7/04:	97545-WC - 1 unit (=$28.80 x 2)	= $57.60
	97546-WC - 4 hrs (x $28.80)	= $115.20
7/8/04:	97545-WC - 1 unit (=$28.80 x 2)	= $57.60
	97546-WC - 6 hrs (x $28.80)	= $172.80
7/9/04:	97545-WC - 1 unit (=$28.80 x 2)	= $57.60
	97546-WC - 6 hrs (x $28.80)	= $172.80
	TOTAL DUE :	**$1,094.40**

- The following DOS, 3/3/04, 3/17/04, and 4/9/04 did not have EOB's provided, according to Rule 133.307 (e)(2)(B), therefore will be reviewed as fee issues.

  a) The following CPT Codes, according to Rule 134.202, have been supported with convincing evidence through S.O.A.P notes or reports that treatment / services were rendered for DOS 3/3/04, 3/17/04, 4/2/04 (CPT code 97140) and 4/9/04. According to Rule 134.202 (c), Medicare participants shall apply the Medicare program reimbursement methodologies. Therefore, reimbursement is recommended as follows.

1)	99213 x (DOS 3/3/04, 3/17/04, and 4/9/04 @ $68.24)	= $204.72
2)	97032 x (6 units x DOS 3/3/04, 3/17/04, and 4/9/04 @ $20.20)	= $121.20
3)	97140 x (DOS 3/3/04, 3/17/04, and 4/9/04 @ $34.13)	= $102.39
	TOTAL DUE:	**$428.31**

  b) Report, CPT code **99080-73** is reimbursed at $15.00 each according to rule 133.106(f)(1). Convincing evidence supports report completed, therefore, reimbursement for DOS 4/24/04, **$15.00**.

  c) CPT Code **97010** (hot/cold pack application) is a bundled service code and considered an integral part of a therapeutic procedure(s) explained in 'MDR Newsletters'. Therefore, per the 2002 Medical Fee Guideline, no reimbursement is recommended.

  d) On 3/31/04 and 4/2/04 CPT **code 97140** was denied as 'Global.' CPT code 97140 is considered by Medicare to be mutually exclusive to CPT 97012. A Modifier would have been allowed, but one

was not noted. CPT code 97012 was reimbursed by the Respondent for DOS 3/31/04 and 4/2/04, therefore additional reimbursed for CPT code 97140 is not allowed.

e) The CPT Code, **97110** for all DOS are not recommended for reimbursement. Review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$1,537.71**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Authorized Signature	Name	6 / 9 / 05 Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____